

**AFFIDAVIT OF COMPLETION OF PHARMACY TECHNICIAN
EDUCATION/TRAINING PROGRAM**



Professional Licensing Agency
Indiana Board of Pharmacy
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Phone: 317-234-2067 fax: 317-233-4236
<http://www.in.gov/pla/>

I, _____, do solemnly swear or affirm under the
(Name of Qualifying Pharmacist)

penalties of perjury, that _____ has completed the
(Name of Pharmacy Technician)

following Board approved program of education or training:

(Name of Indiana Board of Pharmacy Approved Program)

Signature of Qualifying Pharmacist

Pharmacist License Number

Date

Signature of Pharmacy Technician

Date